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<ABS>Abstract

The way in which people approach ill health and its relief is often explained as a function of pragmatic evaluation. Through looking at a case of illness in the family of David Kaso, a Baptist pastor living in rural Malawi, this article suggests that trust or faithfulness may be more appropriate terms with which to describe people's approaches to healing and their social antecedents and outcomes. Pentecostal churches had grown in influence in the area where the churches David led were located. Pentecostal leaders often emphasized that experiencing divine healing, or successfully bringing it about, were the results of the 'work' that Christians did for God. David and his congregants recognized the difficult questions this perspective could raise about their status in church and emphasized instead that healing happened in God's 'grace', largely irrespective of the actions of the Christian. This being the case, the efficacy of prayer as a way of bringing about healing could not really be tested nor, as a corollary, could the outcome of prayer for healing stand as a proxy for evaluating the Christian. The uncertainties David and his church members admitted over healing meant that the basis of their relationships was better described in terms of trust or faithfulness than pragmatism.

<LRH>Daniel Wroe

<RRH>Miracle and healing in Malawi

<AT>**Miraculous healing in rural Malawi: between ‘grace’ and ‘work’**

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David, Martha and Harold all looked worried. They were sat in the gloom of David and Martha’s living room, their faces illuminated by torchlight. It was March, nine months after I had arrived to stay in David and Martha’s house in Chintengo Kubwalo, a Chewa village about 50 kilometres from Malawi’s capital Lilongwe.¹ Harold had come over to David’s from his own house in the village to discuss their youngest brother, Sunday, and the sickness he was experiencing. Sunday had started to get ill the previous week and had gradually deteriorated since. Harold and David had taken him to different healthcare facilities and the previous day Sunday had been to Lilongwe, where David, a Baptist pastor, and a ‘special team’ of other pastors he knew in the city had prayed for healing. However, none of these efforts had arrested Sunday’s decline. Harold had been told at the private hospital where he had taken his brother that Sunday should be admitted for treatment for stomach ulcers. Harold suggested that between them he and David should get together enough money to pay for Sunday to go back to the hospital so that he could get help there. David agreed that Sunday had not been healed by the prayer of the special team, but disagreed about returning him to the private hospital. He talked for some minutes about what he had learned in town with the special team, and summed up by saying:

¹ I spent over a year living in David and Martha’s household from July 2012, followed by further short stays in November 2014 and August 2016. The information in this article is drawn largely from the first period of fieldwork. The names of people, churches and local places have been changed.

<EXT>I myself, I believe that God will heal him. We will pray, we will not be perturbed or weak. They prayed in town – the next stage is to pray and fast. If we remain faithful (*-khala wokhulupirika*)² – he will heal. I believe God. He should not go to hospital because we are praying. Those are my thoughts.

<A>Questions about healing

Opening the first chapter of her book on misfortune in Bunyole, Uganda, Susan Reynolds Whyte (1997) refers to Clifford Geertz's classic work on suffering and religion and his statement that: 'As a religious problem, the problem of suffering is ... not how to avoid suffering but how to suffer' (1977: 104). Whyte, however, writes about how many of the people she spent time with did not bear stoically with ill health, but pragmatically tried to find relief from it. Whyte's work sits in a body of interpretive medical anthropology that has provided an 'explicit critique of the belief model of early public health anthropology, including the assumption that people adopt the cultural models of their society at face value' (Good *et al.* 2010: 4). Anthropologists writing in this tradition have elucidated the reflexivity and pragmatism people display as they respond to illness (Kleinman 1973; Janzen 1978; Good 1994; Jackson 1989; 1995; Whyte 1997; Lewis 2000; 2002). Some studies have emphasized empiricist tendencies (Janzen 1978), while others draw out the fact that people 'do not maintain a constant state of vigilance and rationality' in the face of ill health (Lewis 2002: 16). Whyte acknowledges both perspectives, writing that people in Bunyole, while evaluating their situations pragmatically, were not at the same time 'coldly rational' (1997: 224); too much uncertainty surrounded ill health and healing for this to be the case. It is this tension that I explore through looking at Sunday's illness: the extent to which pragmatic reasoning explains decisions about healing, given the doubts and uncertainties that surround ill health and its relief.

Studies of healing are necessarily studies of social institutions that offer it. Some interpretivist work has been criticized for ignoring the social implications of healing (Singer 2009; Singer and Baer 1995), but case studies such as the one I use here do give weight to questions of power and social order, with which questions about healing are inevitably

² People in and around Chimtengo Kubwalo spoke Chichewa, a language commonly used throughout Malawi. Key Chichewa words and terms are presented in parentheses throughout the article. A hyphen indicates where a modifying prefix would normally be attached to the verb.

entangled.³ Institutions of health and healing are connected to structures of gender, age, ethnicity and class that delimit people's opportunities, conferring more power on some than on others. To argue that people do not hold on to beliefs, or take cultural schemas at face value, is not to argue that there are no structures that shape social life. As Whyte notes, '[there is] ... no contradiction between an appreciation of pragmatism and a concern to explicate ... notions of value, power, personhood, and social identity as they unfold in practise and conversation' (1997: 4).

Equally, though, the fact that significant doubt and uncertainty often surround healing suggests that pragmatism provides only a partial explanation for the way in which people engage with ill health and for the way in which social relations unfold around it as they do. Chewa institutions, public and private biomedical health facilities, as well as Christian churches were all part of a landscape of institutions that offered healing around Chimtengo Kubwalo village and that structured social life in the area. It was the relative influence of the Pentecostal Church in this landscape and on the churches David led that suggested that people's approaches to health and healing were based on something other than pragmatic evaluation.⁴

Pentecostal churches have increased in number and size in Malawi and across Africa over the last thirty years (Englund 2011a; 2001; Maxwell 2007; 1999; Meyer 2004; 1998; Gifford 2004; 1998; 1994; Hackett 1995) and have influenced other denominations and groups of churches over the same period (Mbe 2007; Meyer 2004: 452–3; Ayuk 2002; Maxwell 1999: 215; Asamoah-Gyadu 1997). While explanations of this development have often centred around the 'prosperity' or 'health and wealth' gospel (Meyer 2004: 452–3, 459–60; 1998; Gifford 2004; 1998; 1994; Hackett 1995), these theologies are not reproduced unaltered in Pentecostal congregations; contemporary Pentecostalism in Africa is best described as a

³ Victor Turner's classic extended case studies on ritual among the Ndembu were some of the first ethnographies to describe how the meanings of healing rituals, and the social relations connected to them, emerge in practice (1957; 1974; Werbner 1984; Kapferer 2008). Some studies have focused in even greater detail on individual cases of illness (Niehaus 2013; Lewis 2002; 2000) or religious experience (Engelke 2004) than I do here, but always with a view to connecting these up with their social antecedents and outcomes.

⁴ Relatively little attention has been paid to the church as a healing institution by medical anthropologists. Susan Reynolds Whyte writes that the church was not a particularly important institution of healing in Bunyole (1997: 46). One exception is Thomas Csordas (1994; 1988), who examined healing practices and the phenomenology of healing in charismatic Catholic churches.

diverse movement rather than a uniform denomination (Englund 2011a; Meyer 2004; Maxwell 2000).

There is a rich vein of writing that describes the social continuities that remain in the lives of Pentecostal Christians, for all the emphasis that can be placed on ‘rupture’ in Pentecostal churches (Englund 2007; Jones 2005; Engelke 2004; Maxwell 1998; Meyer 1998). David Maxwell writes that churches in Zimbabwe made only modest promises about advances in their members’ temporal conditions (Maxwell 1998: 366, 370), while Harri Englund argues that Pentecostals he spent time with in Lilongwe focused on achieving what was best described as ‘security’, rather than prosperity (Englund 2011b; 2004). In these churches, a weak connection is drawn between the actions or work of the Christian and their experience of divinely mediated health or wealth, ameliorating the difficult questions that sickness and poverty raise about the Christian’s relationship with God, and their relationships in the church, where the connection is emphasized with more certainty. Such questions may be particularly threatening for pastors, their power as the leaders of Pentecostal churches, often relatively egalitarian institutions, only persisting where they can provide adequate material and spiritual help to their congregants (Maxwell 2007; Englund 2004: 302; Lauterbach 2008: 113). An acceptance of uncertainty and imperfection enables relationships to persist that would otherwise be called into question (Englund 2007). It is on David, as a pastor who offered prayer for healing, that this article focuses.

As Pentecostalism has varied within itself, so too has the manner in which ideas from Pentecostalism have been engaged in churches with their own distinct roots (Meyer 2004: 452–3). Drawing on their history as Baptist Christians, David and many of his church members drew a weak connection between their actions, the outcome of their prayers for healing, and their status in the church, in the face of Pentecostal teaching that suggested stronger links. Christians in the Pamtunda Baptist churches, the group of sixteen small congregations that David led in the area around Chimtengo Kubwalo village, painted a limited picture of their agency and knowledge relative to God’s, in all areas of life, but particularly with respect to the relief of illness. They described how God healed in His ‘grace’ (*chisomo*), irrespective of the ‘work’ (*nchito*) of the Christian. Given this, ongoing ill health could not be used as a pretext for calling a Christian’s place in the church into question, or to raise doubts over David’s position as a pastor. Strong (*olimba*) Christians were

so because they ‘persevered faithfully’ (*-kupilira wokhulupirika*) in the face of illness rather than because they experienced divine healing, or brought it about with any great regularity.

The case of Sunday’s illness, taken together with existing work on healing and on the Pentecostal Church, suggests that it is helpful to understand approaches to healing if not in terms of ‘belief’ then perhaps in terms of ‘trust’ or ‘faithfulness’ (Englund 2007). Through focusing on the pragmatics of healing in Bunyole Whyte (1997) raised important questions about the nature of belief. At the centre of the pragmatic search for healing is a process of testing and evaluation, beliefs are questioned and assessed in light of available evidence. A theology of healing through grace meant, however, that prayer for healing could not really be tested. This made moot potentially difficult questions about the status of the Christian where ill health persisted. Yet, in admitting uncertainty about why healing happens, a theology of grace also raises questions about the nature of the basis for a person’s identity as a Christian, and for their relationship to God and to other Christians. The absence of testable propositions about how healing happens suggests the importance of faith or trust to understanding social life in and around churches as well as other institutions that offer healing (cf. van Wyk 2014; 2011; Whyte 1997).⁵ David’s shift to a more proactive Pentecostal approach towards Sunday’s treatment after visiting the special team in Lilongwe suggests a pragmatic stance; following through the full course of the illness makes more apparent the importance of faith or trust.

<A>Health, healing and society

The approach to healing adopted in the Pamtunda Baptist churches, and by David himself, must be understood in the context of the landscape of healing institutions in the area around Chimtengo Kubwalo and the place of these institutions in the longer, broader history of healthcare and healing in Malawi. Despite an overall decline in the burden of ill health in the country in the last twenty years, Malawians still face significant health problems; the prevalence of HIV/AIDS, tuberculosis and malaria remain high, while widespread malnutrition makes people more vulnerable to ill health than they would otherwise be.⁶

⁵ Writing about ‘hope’, Whyte points towards the analytical limits of pragmatism at the end of her book (1997: 224).

⁶ In 2015, average life expectancy in Malawi was sixty-three years (UNDP 2015: 3) while the infant mortality rate was recorded at sixty-six deaths per 1,000 births in Malawi’s last Demographic and Health Survey (NSO and ICF Macro 2011: 97). Maternal mortality, which has been a particular problem in Malawi, was also high (*ibid.*: 222). During the 1990s, the

Approaches to healing have entwined with gender, age, class and ethnic identities in varied ways through Malawi's history (Messac 2014; McCracken 2012; Hokkanen 2008; Vaughan 1991). Indicators such as mortality and HIV prevalence are connected to a tradition of biomedical healthcare through which certain people have asserted and justified certain kinds of relationships at particular times. Around Chimtengo Kubwalo, power and identity were claimed and contested through biomedical healthcare institutions, Chewa institutions and Christian churches.⁷ That these institutions persisted alongside one another, and that people moved between them with relative ease, implied that significant uncertainty existed about healing and the social relationships connected to it.

Government and private biomedical health services were a very popular option for the treatment of illness in the area around Chimtengo Kubwalo despite frequent complaints about their quality. People told me that the health attendants were often absent from the small local government clinic in the nearest trading centre to the village, Chimsika, or had no drugs (*mankhwala*) to give out. These complaints mirrored those recorded about government health services across Malawi (NSO and ICF Macro 2011: 113). In the event of serious illness, people often tried to get to the main regional referral hospital in Lilongwe, Kamuzu Central. While services are meant to be free at the point of delivery in Malawi (Messac 2014), people said they normally had to pay some money at 'Central'. Factoring in transport to the city as well, the cost of attempting to get treatment there could run to thousands of Malawi kwacha (MK)⁸ – US\$20 or US\$30. Private hospitals, many of which were regarded as offering better care, were even more expensive.

full extent of the spread of HIV/AIDS became apparent in the country; antiretroviral treatments did become more widely available but prevalence of the disease still stood at 10.6 per cent in 2010 (*ibid.*: 197). In 2013, there were an estimated 48,000 AIDS-related deaths (UNAIDS 2014: A57).

⁷ The literature shows that typologies such as this can occlude as much as they reveal about how churches (Englund 2011a: 2; Ranger 1986) and other institutions that offer healing (McCracken 2012: 121–6; Vaughan 1991: 151) are perceived by the people who attend them. This categorization is based on the distinctions people in and around Chimtengo Kubwalo drew, but, given that these distinctions were often contested, and had shifted over time, I use it only heuristically, as a base from which to begin to try to describe the more dynamic empirical realities.

⁸ The exchange rate between the Malawi kwacha and the dollar fluctuated significantly during my time in the village. Here I use a rate of MK 325 to US\$1. All conversions are approximate.

Where there once had been opportunities for many men in the area to earn significant sums of money through migrant labour, first during the colonial period then after independence, such migration had become increasingly difficult since the end of the 1970s (Englund 2002a: 47; Chirwa 1996). Chimsika trading centre was home to a small group of traders, teachers and government health workers, but virtually all of the residents of the surrounding villages, including Chimtengo Kubwalo, were farmers and pieceworkers. These men and women struggled to afford the expenses demanded by a trip to Central.

One important alternative to health centres and hospitals were witchdoctors, *asing'anga*. Chimtengo Kubwalo village had no resident *sing'anga* itself but there were at least half a dozen, both men and women, living in nearby villages. Different kinds of medicines (*mankhwala*) were offered by *asing'anga*, either to provide 'protection' (*chitetezo*) against the attacks of witches (*mfitit*), or to relieve 'natural' ailments. People explained that divination or diagnosis usually took place through a process of questioning (*-kufunsa mafunso*) and reflection (*-kuganiza*), essentially like the approach witchdoctors and diviners have been recorded as undertaking elsewhere in Malawi and across Africa (Niehaus 2013; van Breugel 2001: 213–28; Whyte 1997; Morris 1996: 143–66; Janzen 1978; Marwick 1965: 66–83).⁹ Clients tended to give *asing'anga* a few hundred kwacha, or a small gift of maize, in return for their help. Some charms and treatments from *asing'anga* could cost much more and so it was not necessarily the case that they represented a cheaper option than biomedical treatment.

Perspectives on *asing'anga* and biomedical treatment have connected with other aspects of identity in varied ways in Malawi. The *mchape* witchcraft divination movement that spread among the Chewa and across a swathe of Southern Africa in the early 1930s resembled an older form of divination undertaken by *asing'anga* under the direction of chiefs in the precolonial era. The movement was, however, promulgated by young labour migrants against the continuing authority of chiefs and elders in their home villages (McCracken 2012: 210).¹⁰ As he legitimated his rule of the country over his thirty years in power, independent Malawi's

⁹ There did not seem to be a distinction, observed elsewhere in Malawi, between *asing'anga* as diviners and as herbalists, the latter experts only in the relief of 'natural' ailments (Morris 1996: 143).

¹⁰ The authority of chiefs in colonial Malawi was no more or less 'traditional' than *mchape*; although the exact situation of chiefs varied, to a greater or lesser extent their authority derived from their connection to the protectorate administration, as well as from their connection to people in their villages (McCracken 2012: 225; Eggen 2011: 317).

first president, Kamuzu Banda, similarly imbued Chewa institutions such as the *asing'anga* with new meaning, embracing them even as he emphasized his credentials as a biomedical doctor trained in the UK and America (McCracken 2012: 446–52; Short 1974). Many Malawians have refused fundamental distinctions between these institutions in more recent times (Lwanda 2002). In Chimtengo Kubwalo, reports on the radio of white-collar Malawians' dealings with *asing'anga* were taken as evidence by some that seeking them out was not incompatible with wealth, school education and visits to Kamuzu Central Hospital. The point was made in the face of the assertions of other, mostly younger members of the village, who did express doubt about the efficacy of the solutions offered by *asing'anga*, and their compatibility with a school education (cf. Lwanda 2002: 164).

There were also varied opinions in the area surrounding Chimtengo Kubwalo about the significance of the *Nyau* society, and the *Gule Wamkulu* masquerade dance associated with it. It would be inaccurate to describe the *Nyau* and the *Gule Wamkulu* simply as healing institutions; I was told that all Chewa males were initiated into the *Nyau*, the knowledge or tradition (*mwambo* or *miyambo ya makolo*) of the Chewa being passed on to them during the initiation ceremony. Villagers explained to me that, at funerals and other communal events where the *Gule Wamkulu* took place, the masked male dancers, who formed a special cadre of the *Nyau* society, embodied the spirits of ancestors and clan spirits of the Chewa. Villagers' explanations resonated with work on the history of the Chewa that has emphasized the *Nyau's* place as the 'essential' Chewa institution (Kaspin 1993: 35); the spirits that manifest themselves in the *Gule Wamkulu* evoke the structure of Chewa society through the dance, including appropriate relations between men and women and young and old (Kaspin 1993; Boucher 2012: 6–12; van Breugel 2001: 125–52). It is through the dances that the living might learn about the causes of their health problems and other misfortunes, as spirits reveal the ways in which they had broken the *mwambo*.

While this arrangement seems to leave men with preponderant influence over Chewa society in general and over healing practices in particular, women's own initiation, *Chinamwali* may have provided scope for women to exert significant power themselves (Kaspin 1993: 42–6; van Breugel 2001: 130–1)¹¹. Although initiated women have not historically embodied

¹¹ There is also evidence that Chewa women could become chiefs and therefore have significant influence over *Nyau* and the *Gule Wamkulu* dances. Rangeley notes that female chiefs were relatively common around Nkhotakhota, where he did his research on the Chewa. He does, however, state that they were always advised by male elders (1948: 10). Similarly,

spirits like men have done, *Gule Wamkulu* dances have never been able to go ahead without them, their dancing and singing forming a key part of the events (van Breugel 2001: 130). There appears to have been less room for young people to exert power over their elders, as they were denied access to knowledge, including about health and healing, through the gerontocratic structures of the *Nyau* and *Chinamwali* (Kaspin 1993: 46–7).

Some members of the village felt that they could still gain insights into their temporal predicaments through watching the *Gule Wamkulu*, but much of what I was told about the dance and the *Nyau* and *Chinamwali* cast doubt over whether they should really be described as ‘essential’ institutions (cf. Kaspin 1993). There was no mention of the *Gule Wamkulu*’s historical connection to some of the more violent episodes of Kamuzu Banda’s rule, a criticism of the institution made by other Chewa elsewhere in Malawi (Englund 1996: 107–10). Instead, there were complaints about the relative youth of contemporary dancers and their efforts to ‘extort money’ (*kulambula ndalama*) for themselves through *Gule Wamkulu* performances. Not all young people supported the *Gule Wamkulu*: the same school-educated boys and girls who expressed suspicion to me about the abilities of *asing’anga* were also ambivalent towards the dances. However, most of the criticism came from older people, falling into two distinct categories; some bemoaned the behaviour of the young generation of dancers, but asserted support for the institution as they remembered it had been, while others expressed opposition to it in any shape or form. Several chiefs told me that they no longer arranged *Gule Wamkulu* dances, despite the support the *Nyau* historically provided for the institution of chieftaincy (Kaspin 1993: 36). While a couple of people suggested that women preferred church and men *Gule Wamkulu*, I met women who expressed support for the dance, and who felt that it could help them understand their problems.

While neither gender, age nor class could be used to reliably predict the perspectives people held on the *asing’anga* and the *Gule Wamkulu*, everyone I spoke with stated that attending a Christian church was completely inimical with attendance at *Gule Wamkulu* and with seeing a *sing’anga*. Most of the young people who expressed distaste for the latter institutions, as well as all the chiefs who had abandoned the *Nyau*, were Christians. Their position reflected a historical opposition observed in the literature on Malawi between the Christian Church and

for southern Malawi, Megan Vaughan suggests the power of female chiefs in the past has been overplayed because of a failure to recognize the influence of their male advisers (1987: 125). Pauline Peters (1997) argues, though, that such traditions of male authority were invented during the colonial era as Malawian men jockeyed for power under the British.

autochthonous Chewa institutions (Schoffeleers and Linden 1972; Linden and Linden 1974). The Church of Central Africa Presbyterian (CCAP)¹² and the Catholic missions – the first Christian missions established in the area around Chintengo Kubwalo at the turn of the nineteenth century – denigrated the *Gule Wamkulu* and *asing'anga* (Boucher 2012: 7; Kaspin 1993: 39; Pretorius 1972) and did not offer means to engage directly with the supernatural agents that Chewa people often felt were causing their health problems and other misfortunes (Marwick 1965). Rather, they encouraged people to go to their mission hospitals, which, until the politically subversive *mchape* movement prompted the colonial administration to become involved in public healthcare, were the only biomedical facilities available to the African population (McCracken 2012: 116–20, 260–2; Messac 2014). The CCAP church and Catholic Church in Chimsika trading centre reflected this history, placing little emphasis on ‘spiritual gifts’ such as divine healing.

The position of the Presbyterians and Catholics contrasted with the perspective on divine healing put forward in the half-dozen Pentecostal churches that had mushroomed in the trading centre since the late 1980s.¹³ Several of their leaders expressed the conviction that God miraculously relieved ill health and gave material blessings in response to the work (*nchito*) of the Christian. These pastors were some of the wealthier residents of Chimsika, their position in their churches providing them with the kind of income that was not easy to find in the area given the economic malaise that had persisted there since the 1980s. That one of the pastors was a woman was also significant; for all the questions surrounding the nature of historical gender relations among the Chewa, it was mostly men who wielded public authority around Chintengo Kubwalo when I lived there, suggesting that the patriarchal structure of the colonial government, economy and church had had its effects (Verheijen 2013; Peters 1997; Vaughan 1987).¹⁴ However, the leaders of the Pentecostal churches were

¹² The CCAP was formed by the Northern and Southern Region Scots Missions’ amalgamation with the Central Region Dutch Reformed Church Mission in 1924 (McCracken 2012: 211). It was the Dutch Reformed Church that founded missions closest to the area where Chintengo Kubwalo is located.

¹³ African Independent Churches have played an important part in the history of Malawi (McCracken 2012: 122–32; Shepperson and Price 1958), but they were not a prominent part of the social landscape in the area around Chintengo Kubwalo. There is also a mosque in Chimsika but it was very small and few people outside the trading centre attend.

¹⁴ While the precolonial character of gender relations in Malawi is debated, the patriarchal structure of colonial missions and the colonial economy is less in doubt, even if some women did find that it had advantages on occasion (Verheijen 2013; White 1987: 228; Vaughan 1987: 121–3). Kamuzu Banda did little to change the situation during his rule, but more

not as affluent as the leaders of the CCAP and Catholic churches, whose congregations were also much larger. The mission churches were part of hierarchical denominations that provided church leaders with regular support, while the Pentecostal pastors relied by contrast on the tithes of their own congregations, and the sporadic gifts of foreign missionaries. Even the leader of the oldest and largest of the Pentecostal churches in Chimsika, the Assemblies of God,¹⁵ was not as wealthy as the CCAP minister or the Catholic priest.

The relatively modest position of the Pentecostal churches raises questions about their position on divine healing. Similar questions apply to all the other institutions that offered healing in the area around Chimtengo Kubwalo. Claims to bring about healing were also claims to power and influence there, and intersected with other aspects of identity that situated people socially. The strong claims that some Pentecostal pastors made to know about why miraculous healing did or did not happen were belied by the place of their churches in the local social landscape. Despite people's assertions about their incommensurability, the pastors to whom I spoke, and supporters of the *Gule Wamkulu*, agreed that many people did in fact shift between different churches and the *Gule Wamkulu* and *asing'anga*. The emphasis on conflict between the church and Chewa institutions in the literature is contradicted by historical evidence of similar movement (McCracken 2012: 125–6; Pretorius 1972; Marwick 1965: 64). Such movement, and the persistence of the *Gule Wamkulu*, *asing'anga*, biomedical facilities and the churches alongside each other, implied that the social landscape around Chimtengo Kubwalo was relatively open and that uncertainty about how to deal with ill health was widespread among people living in the area.

Pragmatic processes, testing or trying out different solutions to health problems and responding to results, can explain the movement between institutions offering healing around the village. Yet the weaker the claims to knowledge about ill health and its causes made within such institutions, the less appropriate pragmatism becomes as a term with which to describe responses to ill health. As the history of Malawi indicates, there may be many pragmatic reasons for a person to remain associated with one institution, or move from it,

possibilities have emerged in the multiparty era (Verheijen 2013). Pentecostal churches have provided opportunities for women, as well as young poorly educated men, to accrue the kind of status and influence over older men that they could not command in the past. This change is similar to that which has been described as taking place in other African countries (Gilbert 2015; Parsitau 2011; Lauterbach 2010; Soothill 2007).

¹⁵ The Assemblies of God is one of the most influential Pentecostal churches across Malawi and Southern Africa as a whole (Maxwell 2007: 99, 171; Englund 2001).

regardless of the course their illness takes. This is especially true of institutions such as the *Gule Wamkulu* and Christian churches, which make greater claims on a person than *asing'anga* or biomedical health services, and promise more than just health and healing. Nonetheless, dissonance between claims to know how to heal and persistent ill health must be mediated somehow; there comes a point where this dissonance is difficult to 'ignore' (cf. Whyte 1997: 224). How did Pentecostal pastors in Chimsika reconcile the relatively modest position of their churches and congregants with their claims to knowledge about miraculous health and wealth? Looking at the Pamtunda Baptist churches, and David's response to Sunday's illness, suggests why it is important for people – and particularly for pastors and others who made claims to know how to heal – that at least some uncertainty remains around ill health and its relief. It also shows why, when such doubt is admitted, a perspective on faith or trust is important to the analysis of healing and its social antecedents and outcomes.

<A>Healing in the Pamtunda Baptist churches

The members¹⁶ of the Pamtunda Baptist churches had not historically prayed for the miraculous relief of illness. While this, to some extent, locates them with mission denominations such as the CCAP and Catholic churches, their history and the way in which they responded to the increasing influence of Pentecostal teaching on healing make them difficult to fit into some of the common typological histories of Christianity in Africa (cf. Maxwell 2007: 35–6).

A man named John Moyo had founded Pamtunda Baptist church in the mid-1970s, with the help of American Southern Baptist missionaries who had converted him at a crusade near Chimsika. Having spent the rest of the 1970s leading Pamtunda Baptist, Moyo moved to Lilongwe city in the early 1980s to lead a Baptist church there. With the continuing support of the Southern Baptist missionaries, he started several more churches in the area around Pamtunda and elsewhere in Malawi. By the time I arrived in Chimtengo Kubwalo, David, who had taken over the leadership in the late 1990s, was responsible for sixteen churches in a

¹⁶ The term 'membership' requires some definition, since what it means varies among denominations and church movements. Unlike membership in the CCAP and Catholic churches, which had historically been the end point of an institutionalized process of classes and catechism (Linden and Linden 1974; McCracken 1968), de facto membership of the Pamtunda Baptist churches happened simultaneously with a person becoming a Christian on baptism. The absence of any kind of 'test' for membership is another reason to see trust as the basis for relationships in the churches.

15 kilometre area around the village. Collectively, the congregations were known as the Pamtunda Baptist churches, after the original church. Pamtunda Baptist itself, which was the closest to Chimtengo Kubwalo, was the largest church, numbering around one hundred congregants on the busiest Sundays. Given the high density of the population in the area, this represented relatively few people. Not many people from Chimtengo Kubwalo attended Pamtunda Baptist; in a simple survey of the village that I completed during my first weeks there, I counted ten adults attending Pamtunda Baptist and two the Catholic church in Chimsika, while twenty-one said they went to *Gule Wamkulu* dances.

Attendance at the churches varied dramatically throughout the year. Pamtunda Baptist church was fullest after the harvest, in June, July and August, while during the hungry season earlier in the year attendance often dwindled to just a dozen people. Women and younger people were always in the majority, while women also made up a significant proportion of the lay leadership of the church. The same patterns existed at the other Pamtunda Baptist congregations, all but one of which were situated in villages, and were significantly smaller than Pamtunda Baptist. The exception in terms of location, Chimsika Baptist, numbered only a handful of people, none of whom belonged to the wealthier class of people who lived in the trading centre. The location of the churches largely within villages explained the seasonal pattern of attendance, and their poverty; I calculated that average giving at Pamtunda Baptist on Sunday was just MK 970 (US\$3) over the course of one year.

While recognizing their poverty, David also blamed the churches' paucity of resources on the 'weakness' (*-kufooka*) of some of their members. Like the Pentecostal pastors in Chimsika, he bemoaned the fact that there were many people who participated in church services and other activities for a period, before stopping, perhaps going to another church such as the Assemblies of God, or to the *Gule Wamkulu*, and then returning to one of the Pamtunda Baptist churches again. As my time in the village went by, I saw several people change religious affiliation, casting the usefulness of my initial survey in some doubt. Many people did not attend a religious institution with any regularity at all, adding weight Mia Green's (2006) argument that the basis of social life in Africa is not essentially spiritual. People's use of biomedical facilities was much more consistent; Sunday's case aside, I saw only one person refuse to explore biomedical treatment when they became ill. Gauging how many people used *asing'anga* and how regularly was harder, given that people were much less

open about their interactions with them than about their trips to hospital or church or their attendance at the *Gule Wamkulu*.

Perhaps unsurprisingly, given my residence in David's household and attendance at his churches, few 'weaker' Christians directly questioned the efficacy of the means offered at the Pamtunda Baptist churches for dealing with ill health or the other difficulties they faced.¹⁷ Neither did people who had never been to church. Most blamed their absence from church on the work they had to do in the fields, or elsewhere, or on their 'laziness' (*ulesi*). They said the same things to David and to other church members whom I saw try to encourage them to attend. One of the most forthright supporters of the *Gule Wamkulu* whom I got to know was a woman named Esnarth Mitambo. She refused to go to the health centre when she got sick, suggesting that it would be better for her to go to the *sing'anga*. David and Martha had encouraged her to go to the Chimsika health centre and also frequently suggested that Esnarth should come to church. Esnarth tended to laugh loudly when they did so, and say indignantly 'Me? No, no, no!' or something similar. Once, when Chimtengo Kubwalo village was preparing to host a *Gule Wamkulu* dance, I asked Esnarth why she preferred to go to *Gule* and *sing'anga* and not to church. Esnarth laughed, saying: 'To church? To worship, to pray? No, no, no. There is no point. But to *Gule*, to dance. You should come to *Gule*, you should go to the *dambo*¹⁸ and be initiated.'

The ambivalence many people felt towards the Pamtunda Baptist churches meant that the idea that God might be prompted to answer prayers for healing in response to work or a demonstration of faith was appealing to David; his power and influence as a pastor might stand to increase significantly should this turn out to be the case. Organizationally, the Pamtunda Baptist churches were much like the Pentecostal churches in Chimsika in that they were relatively independent of central authority and had no regular material support. David

¹⁷ David assumed that I was a missionary when Pastor Moyo first introduced me to him when I was looking for a place to do my PhD fieldwork. Other anthropologists working on the church in Africa have also been assumed to be missionaries (Englund 2001: 244; Soothill 2007: 5–6). In my case, the label was hard to shake off once David had established that I was in fact a practising Christian. As the article shows, I did not try to keep my thoughts regarding church and faith to myself, as, like other anthropologists, I felt I could learn more by adopting a position with which people could engage, rather than trying to avoid any position at all (Niehaus 2013: 22; Hutchinson 1996: 45). I was limited in some ways – with regard to the extent to which I could participate in the *Gule Wamkulu* and in divination, for example – but enabled in others.

¹⁸ The secret place where *Gule Wamkulu* dancers prepare for dances, often a gravesite.

continued to farm to meet his family's subsistence needs, the little money he received from his congregations and the occasional gift from a foreign missionary being far too little to rely on alone. Moreover, David's sense of identity was deeply rooted in his position as a pastor and he was anxious to perform the role well, frequently telling me that it was important to him to have knowledge about all kinds of theologies and church practices. If pastors should be able to bring about healing, then healing was something that David felt he needed to do.

If the independence of the churches meant that David had little in the way of a secure income, it also meant that there was little pressure from outside the churches to lead them in a particular way. David had been trained to be a pastor at a Baptist seminary in Lilongwe under John Moyo's guidance, but Moyo and David now only met irregularly. Since his training and ordination as a Baptist pastor, David had attended several short courses at the Assemblies of God Bible School in Lilongwe (Englund 2001: 243), as well as regularly meeting with Pentecostal pastors in Chimsika trading centre and at his own home. David knew that many Pentecostal pastors described the Christian's connection to God as a reciprocal relationship: work for the church was returned with the miraculous blessings of health and wealth.

The leader of the Assemblies of God church in Chimsika, Pastor Mphatso Sibande, summed up the position when David invited her to Pamtunda Baptist to help him lead a service there. The service was a 'Paper Sunday', which, like the 'Big Sundays' David Maxwell describes as taking place in Zimbabwe Assemblies of God churches (2007: 152), focused on raising financial support for the church from its members. David explained to me that Paper Sunday and the discourse about miraculous health and wealth that was a part of it were 'from the Assemblies'. Pastor Sibande repeatedly stated during her address to the congregation that: 'You give to God and God gives back to you.' She described how the likelihood of seeing miraculous change in their level of prosperity and their state of health was connected to their work for the church and the material support they gave it.

Some people in the assembled congregation shook their heads at her, and looked anxious as Pastor Sibande exhorted them to give. Many of the members of the Pamtunda churches had avoided coming to the service, telling me before or after that they did not want to be made to feel 'ashamed' (*-chita manyazi*) by the fact that they had nothing to give. When I spoke to a couple of members who had been at the service, they questioned whether what had gone on at Paper Sunday was 'not Christian': 'To go on like that? It is just to shame people.' Despite inviting Pastor Sibande, David himself expressed some ambivalence when I questioned him

about how the message she had preached matched up with other ideas he had expressed to me about healing taking place through God's grace, ideas I had told him that I shared. 'Maybe it is not good to force giving like that ...' David admitted, before going on, 'but the Assemblies are big churches and very rich, and you know, Dan, the Baptist churches are poor, and people do not give anything, so we try this way.'¹⁹

The reactions of the members of the Pamtunda Baptist churches to Pastor Sibande's preaching on Paper Sunday were reflected in the history of the churches and contemporary practice within them. Southern Baptists have traditionally been cessationists, believing that God ceased to grant the gift of divine healing and other spiritual powers at the end of the period of history covered by the Bible (Richards 2012). At the beginning of the 1990s, Moyo took the churches he had started out of their association with the Baptist Convention of Malawi (BACOMA), the name of the national group of churches initiated through Southern Baptist missionary work. Moyo explained to me that he left the convention in order that people in his churches might benefit from the 'things of the spirit', including divine healing. BACOMA's leadership had remained cessationist despite the growing influence Pentecostal teaching was having in BACOMA Baptist churches (Longwe 2011: 477–8).²⁰

Despite the reason he gave for it, and the fact that the split from BACOMA coincided with the growth in popularity of Pentecostalism in Malawi and Africa more widely, Moyo was ambivalent about aspects of the Pentecostal teaching on spiritual gifts. When he visited the Pamtunda Baptist churches, rather than suggesting that 'work' (*nchito*) for the church or a certain level of 'faith' (*chikhulupiriro*) might result in divine healing or other miracles, Moyo emphasized that these occurred only through God's 'grace' (*chisomo*). He stated the necessity of trusting God and remaining faithful (*-khala wokhulupirika*) even in the absence of miraculous changes in circumstances. On one occasion he spoke on the book of Philippians,

¹⁹ Although it was not commented upon by members of the Pamtunda Baptist churches, it is worth pointing out that the relatively modest position of the Assemblies of God church in Chimsika suggests that the strong message about the connection of health and wealth to work for the church that Pastor Sibande preached on Paper Sunday was in fact mutable in the context of her own church. This would fit with David Maxwell's argument that the theology of health and wealth has persisted in tension with other kinds of teaching in Assemblies of God churches in Zimbabwe (Maxwell 2007).

²⁰ The relative ease with which Moyo was able to leave BACOMA reflects the egalitarian congregationalism of Southern Baptist Christianity. Individual Baptist congregations have historically had the freedom to develop their own distinctive positions on doctrine and practice, and to move out of association with other churches when positions conflict.

where the Apostle Paul explains that he knows ‘how to be brought low’ and ‘how to abound’ (*The Bible* 2011: 982). Moyo encouraged the congregation to take their example from Paul and persevere in difficult situations. During another visit, Moyo spoke about how leaders had the power to lead, but that this power was ultimately from God and given in ‘grace’. Leaders should not, therefore, be ‘proud’ (*onyada*) and assume that gifts such as healing were given to them by God in exchange for the work they had done for Him.

The practice of healing at the Pamtunda Baptist churches, like the teaching of Moyo, contrasted somewhat with that recorded in many Pentecostal churches, and in other churches influenced by Pentecostal teaching. Prayer for healing did not take place in public each week (Werbner 2011; Maxwell 2007; Mbe 2007; Meyer 1998; Asamoah-Gyadu 1997). The form and content of services were set out in printed instructional materials and a hymnal – old publications written by Southern Baptist missionaries when they started working in Malawi in the 1960s and 1970s. There was an emphasis in them, and across the services I attended, on the importance of God’s grace in the life of the Christian, whose strength was evidenced in perseverant faith in all circumstances, rather than by their success at bringing about healing or other miracles.

An emphasis on grace was also a feature of church members’ testimonies. People talked about how they understood events subsequent to their conversion in reference to God’s grace. David described how the decade following his conversion in 1993 had been frustrating as, like so many young urban migrants at the time, he had struggled to obtain steady employment in Lilongwe (Englund 2002b: 139–41). David explained to me that he now saw the period as an example of God’s ‘grace’; his failure to get a job in town forced him back to Chimtengo Kubwalo, where he eventually became the pastor of the Pamtunda Baptist churches. David mentioned that several bouts of severe illness had followed, keeping him ‘grounded’ for weeks, but that he had always persevered faithfully (*-pilira wokhulupirika*), despite only seeing his afflictions relieved miraculously some of the time.

Other church members had similar stories. For example, when we visited their home, Titani and Chipiliro Jere described to David, Martha and me how their house had burned down several years before. They explained: ‘We just kept praying, though, and coming to church. We trust God.’ Titani had also been very ill the following year, but ‘kept praying and trusting God’ even when miraculous healing had not been forthcoming. She slowly recovered over

time. As we walked home, Martha and David agreed that the Jeres were ‘very strong Christians’.

Despite the fact that prayer for healing did not take place during services, David did say that he had come to see it as an important part of his role as a pastor. He visited the homes of the sick to ‘comfort’ (*-pepepetsa*) them on average once or twice a week. I saw him pray for healing on these calls around a dozen times. Sometimes people described an accident, or someone simply getting sick, while on other occasions they wondered about witchcraft, spirits and the influence of ‘Satan’. David’s prayers did not tend to reveal explanations or agents behind people’s conditions, but only invoked the ‘power’ (*mphamvu*) of God to heal the illness and remove any malign influence causing it.²¹ I never perceived any sudden, miraculous change in a person’s condition after they had received prayer, but David and several Pamtunda Baptist members assured me that sicknesses had been relieved miraculously through prayer in the past. David always counselled that the sick person and their Christian relatives should ‘persevere faithfully’ in prayer, and sometimes told his testimony to ‘encourage’ or ‘strengthen’ (*-kulimbikitsa*) those present, illustrating the fact that sometimes God used difficult situations for positive ends. David would also normally give the family some money to help them pursue medical care at Chimsika health centre or at Kamuzu Central Hospital.

The fact that people did not always recover from illness never appeared to raise questions about their status as a Christian, or the amount of work they did for the church. Neither was David’s position as the pastor of the Pamtunda Baptist churches called into question because so little miraculous healing happened as a result of his prayers. When people did recover from illness, often over time, or after a visit to Kamuzu Central Hospital, David and other

²¹ It is mainly for this reason that I have not engaged with the extensive literature on disease aetiology in Africa and the kind of social questions that the agencies that are perceived to be behind illnesses may raise. Terence Ranger argues that the aetiological distinctions that had informed historical efforts at healing in Zimbabwe were collapsed by Pentecostalism as it made ‘available the healing power of the Holy Spirit’ to counter all kinds of illness (1982: 339; cf. Whyte 1997). David and members of the Pamtunda Baptist churches similarly felt that God could engage any malicious agent that might lie behind an illness, or an illness without an agent behind it. David explained to me that witchcraft, and spirits of all kinds, were ‘Satan’s processes’ for harming the Christian, and that as such the same kind of prayer for healing was appropriate irrespective of who or what was causing the problem. While suspecting that someone was causing a disease could cause worry, the advice in the Pamtunda Baptist churches was always to pray and to carry on as normal as much as possible (cf. Ashforth and Watkins 2015).

‘strong’ (*olimba*) Christians credited it to God’s ‘grace’ rather than to the work the person had done for the church, the money they had given, or the particular level of faith they had. In emphasizing a stronger connection between actions or work and health or wealth, David stood to gain more power and influence as a pastor. But there were also greater risks. Were he to put forward the theology of healing Pastor Sibande had preached on Paper Sunday, doubts over his status as a Christian, not to mention the positions of his church members, would be much harder to mediate in cases where illness persisted. A theology of healing through grace, in emphasizing the limits of human knowledge and agency, ameliorated such doubts.

However, if healing happened through grace, and if prayer for healing was not a method amenable to being tested or ‘tried out’ (cf. Whyte 1997), this raises questions about the basis for a person’s identity as a Christian. In the Pamtunda Baptist churches, people found their identity as Christians through perseverance in the presence of uncertainty; being a ‘strong’ (*olimba*) Christian was not to experience or successfully bring about divine healing, but to persist through trials such as illness, which God might or might not remove as He saw fit, irrespective of the work or action of the sufferer. This perseverance is not best described in terms of pragmatism but in terms of faith or trust; these were the terms the members of the Pamtunda Baptist churches used. Looking at David’s response to Sunday’s illness further illuminates why grace was important in the Pamtunda Baptist churches and why it calls for an analysis of healing and sociality based on trust or faithfulness.

<A>Sunday gets sick

Aged nineteen, Sunday was much younger than his elder brothers David and Harold. He had been dependent upon them since he had left their parents’ house in another village to come to Chimtengo Kubwalo in 2006. Sunday first stayed with David, before moving in with Harold while I was in the village. He worked for both brothers in their fields. The family regarded him as a hard worker, less flighty or rebellious than some young people in the village, and his general acquiescence to the wishes of his elders was reflected in the way in which he went along with their instructions after he got sick. Sunday, like many young, unmarried people in the area around the church, was also very committed to Pamtunda Baptist. He had been converted and baptized by David when he arrived in Chimtengo Kubwalo and attended the church every week.

Sunday's illness had come on quite gradually at first. He complained of stomach ache before vomiting a couple of nights later. The following morning, Harold and David agreed that David should take Sunday to the health centre at Chimsika. When David and Sunday came back from the health centre in the afternoon, Sunday showed me about half a dozen paracetamol pills wrapped in a small twist of newspaper. Sunday took the pills over the next couple of days. We also prayed for Sunday that evening. Despite Sunday's fragile condition, David decided to leave Chimtengo Kubwalo for a four-night residential pastors' training course run by American missionaries at the Malawi Assemblies of God Bible School in Lilongwe. Sunday was, however, on his mind as he departed the village. 'These days everything needs money – Sunday sick, money; transport to town, money; for the children to go to school, money.' When I tried to reassure him that I would be happy to pay for Sunday to get to a hospital should he need it, David thanked me, but reminded me that I had already spent a lot helping the family and church members with food during the current hungry season, which would be continuing for at least another month.

That night, Harold and his wife Ethel came to David and Martha's house, woke up Martha, and then woke me up. Sunday had been vomiting violently. Although the bout eventually eased the following morning, Harold took Sunday to a new private clinic at a trading centre called Katete on the tarmac road to Lilongwe. It had opened only a few months earlier, but Harold and David had heard talk that it was a good facility and not as busy as Kamuzu Central Hospital. It was a long way from the village, but not quite as far as Central. When they got back late in the evening, Harold explained that the doctor had told them Sunday had stomach ulcers, and that his condition was critical. He had advised Harold to bring Sunday back in a couple of days' time so that he could be admitted for treatment. Harold said that the clinic had been good, but that he was concerned about the cost of taking Sunday back; it had been MK 3,700 (US\$11) just for the consultation. I phoned David in Lilongwe and told him the news. David asked if I could pay for Sunday to get transport into Lilongwe. I agreed and the next day Harold took Sunday to the tarmac road, where he caught a ride alone into the city.

Over the course of the next day, several Pamtunda Baptist church members passed by and enquired after Sunday. When Martha explained that he had been to the Katete hospital and had now gone to town to Central, the church members affirmed the decision, and commented that they would be praying that he got better. Several encouraged 'faithful perseverance'.

Sunday returned to Chimtengo in the evening. He said that he had not seen much of David, who had spent most of the day at his training course at the Assemblies of God campus. David had, however, joined with some other pastors to pray for him. Surprised, I asked whether Sunday had been to Kamuzu Central Hospital, as I had assumed that this had been David's purpose in calling for Sunday to come to Lilongwe. Sunday corrected me, explaining more about the pastors. A 'special team', they had a reputation in the city for mediating miraculous healing. They led different churches across Lilongwe, including some Pentecostal congregations. Sunday said that he had felt better as soon as the pastors had finished praying. Martha, who was as surprised as me that her brother-in-law had not been to hospital, expressed her doubt that Sunday was actually better. Harold questioned his brother's health as well, asserting that: 'He should have gone back to Katete.' During the night, Sunday started vomiting again.

David got back from Lilongwe late the following afternoon. He said that the prayer for Sunday with the special team of pastors had been a 'good time' but did not look convinced when Sunday told him that the prayers had healed him. When Harold came over in the evening to discuss Sunday's condition, both men, and Martha, looked extremely worried. I offered to pay for Sunday's treatment at Katete myself, but David and Harold were both reluctant to accept more money from me, explaining that I had already helped them a lot. Harold suggested that they could find the money between themselves and get some more from relatives to pay for the treatment. It was when Harold had finished arguing for attempting to get money together to pay for Sunday to go back to Katete that David asserted that no biomedical care should in fact be sought, and that he was trusting Sunday's healing to prayer and fasting alone: 'They prayed in town – the next stage is to pray and fast. If we remain faithful (*-khala wokhulupirika*), he will heal.'

Harold, as he often did when he disagreed with his brother in his presence, was silent at David's pronouncement. One of Sunday's favourite jokes with me was about the fact that his elder brothers were never able to agree and were 'always in competition'. David and Harold had received a joint inheritance that was a constant source of friction, but their differences also extended to their views on Christianity. Harold did not go to Pamtunda Baptist, which disappointed his brother. Given, however, that David did not normally discourage people from seeking biomedical care at the hospital, the brothers did not often disagree about the treatment of sick family members.

After Harold had left us, David explained to me that he had got the idea to pray, fast and refuse medical care at a hospital or clinic from one of the pastors on the special team.²² While he had used the term ‘remaining faithful’, relying on praying and fasting as a ‘next step’ was more like an attempt to demonstrate a level of faith in God that would make Sunday’s healing more likely: ‘To go to hospital is to show weakness,’ David explained. In asserting more specifically how healing would be brought about, David was implying that healing was not in fact brought about through God’s grace, but prompted by the work or action of the Christian. He would fast until Sunday got better.

I argued that David should listen to Harold’s suggestion and return Sunday to hospital, pointing out that we could continue to pray for him while he was there, as David had done when other Pamtunda Baptist church members had been seriously ill. David continued to refuse. As I went to bed, David said: ‘I am not afraid, Dan. I know my God will heal him.’ When he got up the next day David went without his morning tea and bread, and ate neither lunch nor dinner. Sunday spent the day around David’s and Harold’s houses; he was not vomiting but complained of tiredness. In the evening, Harold came over and said that he had heard rumours that Sunday’s illness might be being caused by witchcraft. David and Harold discussed what Harold had heard, David telling us that the special team in Lilongwe had also suggested that witchcraft might be behind Sunday’s sickness. Ashforth and Watkins (2015) write that Malawians often treat the failure of biomedical treatment as evidence that witchcraft is causing a health problem. Harold, however, continued to argue that Sunday should go back to the hospital at Katete, even as he gave credence to the rumours of witchcraft. When I asked David whether he had changed his perspective on Sunday’s treatment because the special team had raised concerns about witchcraft, he said he had not. He restated his position of the previous evening, saying that he would continue to fast and pray, and that Sunday should not go to hospital.

Sunday got worse again that night. One of his legs swelled up dramatically while his stomach remained painfully distended. In the morning I found him lying impassive outside David’s house on a reed mat. He was no longer saying that he was better. A steady stream of people from the village and from Pamtunda Baptist came to visit him. David did not mention to any

²² While generally Pentecostals embrace biomedicine, only shunning ‘traditional’ medicines, there are times when they have called the influence of the former into question as well. David Maxwell writes that Pentecostals in Zimbabwe have repudiated biomedical care at some points (2007: 48), as does Matthew Engelke (2004: 93).

of them that he was no longer looking to take Sunday to a hospital, but trusting his healing to prayer and fasting alone. He admitted to me that he was ‘very scared’. When I talked to Harold, he also expressed his concern for his younger brother, and some frustration with David: ‘Sunday is very sick. David just wants to pray, but Sunday is not getting better.’ When I asked Martha why David was not taking Sunday to hospital, she said he was ‘praying and trusting God’ and that she was doing the same.²³

David had not eaten breakfast but, just before midday, suddenly broke his fast, taking me to drink tea and eat ‘scones’ – small bread rolls – at the local teashop. As we walked there I asked David why he was giving up on fasting. David replied he was ‘feeling hungry’ and said no more. After finishing his tea, David told me he would take Sunday to Chimsika health centre that afternoon. Shortly afterwards he heard from a passer-by that a mobile clinic would be setting up at Kuulalo village the next day. The clinic was run by a charity and was known for providing cheap medicines. David decided he would take Sunday there. When he told Martha and Harold he would take Sunday to Kuulalo for treatment, they both agreed that Sunday should go. Harold listened to his brother’s change of heart without showing any obvious surprise or resentment. No one mentioned David’s resolution that he would not take Sunday for biomedical care, but pray and fast to prompt Sunday’s recovery.

Very early the next morning, as it was getting light, Sunday and David departed for Kuulalo. They came back early in the afternoon. David explained that the examination by the clinic’s doctor had confirmed that Sunday had ulcers in his stomach. Sunday had been given some medicines, David paying the small MK 500 (US\$1.50) fee for them, and told to come back to the clinic when it returned to Kuulalo. Harold nodded as David spoke, asking a few questions about what the doctor had said, before reading the label on Sunday’s pills. He commented that it was good medicine and headed back to his house. Sunday got better quickly and David, Martha and Harold all remarked on the efficacy of the medicine, as did many of the people from Chimtengo Kubwalo and Pamtunda Baptist who came to check on Sunday’s

²³ David’s wife Martha led the women’s group at Pamtunda Baptist church. Although she and other lay female leaders had public influence in the church, unlike in the Assemblies this tended to be limited to directing other women. Martha was regarded as a strong Christian and in private could be forceful in making her opinions known to David when she felt that he was in the wrong. The uncertainty David admitted as a Christian made him open to her counsel, which he said he appreciated even though they did sometimes argue. In this case, although Martha had been surprised by the fact that her husband had not taken Sunday to Kamuzu Central Hospital, she did not strongly disagree with his decisions over Sunday’s treatment.

progress. Several of the church members also said that ‘God should be praised’ for the change in Sunday’s condition. David agreed enthusiastically when they said this, and thanked God for Sunday’s recovery in his own prayers each night for several days, giving thanks that God had done it in His ‘grace’ (*chisomo*) and ‘power’ (*mphamvu*).

Subsequently, neither David nor anyone else brought up his change of heart towards Sunday’s treatment. In the weeks after Sunday’s visit to Kuulalo, I twice asked David why he had decided against biomedical treatment, but had then given up on prayer and fasting alone, in favour of taking Sunday to the Kuulalo clinic. He avoided answering the question. When I asked about the rumoured witchcraft, David said that he would ‘keep quiet and pray to God for protection’ (cf. Ashforth and Watkins 2015). Martha said that her husband had just changed his mind, as did Harold when I asked him about what had happened. During services at Pamtunda Baptist and during his visits to church members, David emphasized the way in which God acted in the lives of believers in His grace. He continued to pray for the healing of members of his congregations in their homes, as he had done before Sunday’s illness. He and the church members he prayed for talked about the importance of faithful perseverance (-*kupilira wokhulupirika*), in the absence of miraculous intervention. David did not again suggest that by refusing biomedical care a believer might stand a better chance of receiving or mediating divine healing from God.

<A>Healing, grace and faithfulness

What happened during and after Sunday’s illness shows why healing through grace was an important idea to David and to the people in his churches, and suggests that pragmatism may not always be the most appropriate term with which to explain the way in which people engage with ill health. Claims to know how to heal, in conjunction with other aspects of identity such as gender, age, class and ethnicity, have been a basis for the power of different people and institutions in Malawi at different points in time. In the last thirty years, Pentecostal churches and pastors have become increasingly influential in the country, as they have across Africa. However, for all the strong claims to knowledge made about health and healing, like those that Pastor Sibande made at Paper Sunday, there is also evidence of significant uncertainty among the leaders and members of Pentecostal churches about why healing happens (Werbner 2011: 24, 42). These uncertainties are similar to those Whyte notes diviners and their clients expressing in Bunyole: ‘Both ... want to create certainty, but they are not naive about the difficulty of the task’ (Whyte 1997: 81).

Ilana van Wyk (2014; 2011) has described pastors in the Universal Church of the Kingdom of God (UCKG) in South Africa making unequivocal claims to knowledge about how to bring about miraculous health and prosperity, encouraging church members to test those claims pragmatically. It is the strength of the claims and causal connections the pastors make that permits testing, but which also leave neither the pastors nor church members with much option other than to move on when healing and other miraculous blessings are not forthcoming. By contrast, the admission of greater uncertainty allows relationships to persist, while also raising a question about the extent to which it is useful to describe the basis of those relationships through reference to pragmatism (cf. van Wyk 2014; 2011; Whyte 1997).²⁴

In the Pamtunda Baptist churches, the theology of healing through grace meant that the outcome of prayer for healing could not be used as a test of a Christian, to call into question their relationship with God and their status in their church. In his work on Pentecostalism in Chinsapo township in Lilongwe, Harri Englund makes a similar critique of the category of belief to that made by interpretivist medical anthropologists.²⁵ However, instead of turning to pragmatism for an explanation of the form social relations took in their churches and outside them, Englund argues that Pentecostals' relationships were best explained in terms of trust or faithfulness²⁶. Acknowledging their doubts and imperfections, Chinsapo Pentecostals exhibited 'considerable forbearance' (Englund 2007: 485); relationships persisted that would have dissolved in the face of the kind of pragmatic assessment that van Wyk describes taking place in the UCKG. The modest perspective on the capacity of the Christian in Chinsapo Pentecostal churches was like that implied by the theology of grace in the Pamtunda Baptist churches. In particular, the churches' members accepted that they were limited in what they

²⁴ For a discussion of the relationship between uncertainty and sociality in different African contexts in general, see Cooper and Pratten (2015).

²⁵ Like Byron Good (1994), Englund bases his arguments on the work of Wendell Smith (1977), who argued that historically Christian belief was a term that described a relative measure of commitment, rather than the acceptance of a proposition. Englund also references Malcolm Ruel's (1997) work; Ruel draws out a similar point to Smith through contrasting concepts of belief in Christianity with those in Bantu religion.

²⁶ The Chichewa adjective *wokhulupirika* ('faithfully') is related to the noun *chikhulipiro*, which is variously translated as 'faith', 'belief' and 'trust'. Based on his observation of social life in the Pentecostal churches in Chinsapo, Englund argues that 'faith' or 'trust' was the most appropriate translation. Given my evidence, I have followed suit here.

could do to bring about healing; it took place only in God's grace.²⁷ Given this perspective, it was not that surprising that no one questioned David as a result of his inability to heal Sunday through his Pentecostal-inspired effort at prayer and fasting. Sociality in the church depended on faithful perseverance in God in the face of sickness rather than the pragmatic assessment of the outcomes of prayer for healing.

David's position and power in the Pamtunda Baptist churches were, of course, about more than his faithfulness in God in the face of ill health and disease. While he was not as wealthy as many of the other church leaders in the area, David was better off than most of his church members. The contributions he made towards funerals and weddings, the food he gave to help church members survive the hungry season, as well as the money he provided to help pay for trips to Kamuzu Central Hospital, were important to his congregants. His ordination also marked him as someone who could officiate at events such as weddings and funerals; the Pamtunda Baptist churches were not so non-hierarchical that any member of the church could lead such ceremonies. Finally, even though the Pamtunda Baptist churches provided significant scope for women to exercise public leadership, and despite the fact that the subject had not been brought up directly when she came to speak on Paper Sunday, many women and men in the churches were ambivalent about female pastors such as Mphatso Sibande. David's gender, ritual knowledge and material resources all undoubtedly contributed to his position in the Pamtunda Baptist churches and made it less likely that his position would be called into serious question.

But faithfulness in the face of illness still mattered; what was surprising about the case of Sunday's illness, at least to me, was the ease with which people accepted David's vacillation over his brother's treatment. Strong Christians would sometimes question whether those in their number, people like Harold, who did not come to church much, or the people who vacillated between *Gule*, *asing'anga* and the churches, were in fact Christians at all. Esnarth Mitambo and other faithful supporters of the *Gule Wamkulu* sometimes wondered about the latter individuals too, and whether they were truly 'of the *Gule*' or not. In this sense, faithfulness in God in the face of ill health represented something of a test; experience and

²⁷ China Scherz (2013; 2014) has discussed the implications of a similar perspective on human limitation, relative to God, among Catholic nuns who ran an orphanage in Uganda. Scherz describes how the nuns saw limited value in financial budgeting or planning, trusting instead that God would provide for them largely irrespective of their efforts in this regard.

evaluation were not irrelevant to the analysis of the social aspects of healing in the Pamtunda Baptist churches.

Faithfulness in God did not, however, stand as a test in the way that the ability to bring about divine healing did in churches such as the UCKG. The very fact that people could shift back and forth as they did indicated that there was little basis or desire to exclude people from church or the *Gule Wamkulu* completely; the labels ‘stronger’ and ‘weaker’ Christian were relative distinctions rather than categorical ones. While faithfulness in God could be evaluated, the human imperfections and limitations that David and his church members accepted meant that it is more appropriate to describe their relationships as built on faith and trust, rather than on a more calculated, pragmatic kind of assessment. Pamtunda Baptist members emphasized how God healed in His grace, but they also talked about the need to show grace to each other, not judging a Christian on the basis of their actions, but extending trust and allowing them to continue to be part of the life of churches.

It was not clear exactly why David acted as he did over Sunday’s illness. His fears about Sunday’s health and witchcraft, his financial situation, and his relationships with Harold, members of his churches, other pastors and me are all relevant.²⁸ What is important here, though, is more the fact that David’s shifts in stance towards Sunday’s illness, his apparent lack of faithfulness in God, did not call his status in the churches into serious doubt. Perhaps his church members’ faith in him would have been stretched more had he gone to the *Gule Wamkulu* or consulted a *sing’anga*. As it was, I was the only person asking questions.

The fact that David was reluctant to answer my questions suggests that he recognized the awkwardness of the dissonances between his vacillations over Sunday, his professed faithfulness in God and his leadership of the Pamtunda Baptist churches. In re-emphasizing grace after Sunday’s illness had passed, David called up the doubts that existed about ill health and healing for all the members of his churches, their own human limitations, and the consequent importance of trusting each other, as well as God, when evidence might suggest doing otherwise. It was to grace that David referred when he eventually gave me something of an answer to the questions I had put to him about his actions over Sunday’s illness. Months after the episode had passed, just before I left his home to return to the UK, David asked me what I had found difficult about living with him and his family. I answered that,

²⁸ The anthropology of health and healing has shown how difficult isolating the causalities that surround specific health decisions can be (Niehaus 2013).

among other things, I had struggled with his decision not to let Sunday go to hospital. David nodded and said: ‘You know, Dan, we are all some parts good, some parts bad. It is only by God’s grace I live.’

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